Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
517 NORTH CARRIER PARKWAY SUITE G
GRAND PRARIE TX 75050

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3796-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No EOB/Pre-authorized - #100623-185885."

Amount in Dispute: $12,643.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2010 July 7, 2010 July 9, 2010 July 12, 2010 July 13, 2010 July 14, 2010 July 15, 2010 July 16, 2010 July 21, 2010 July 22, 2010 July 28, 2010 July 30, 2010 November 15, 2010 November 16, 2010 November 17, 2010 November 29, 2010 December 1, 2010 December 3, 2010 December 6, 2010	Chronic Pain Management – CPT code 97799-CP (4 hours x 19 dates = 76 hours)	$400.00/day	$7600.00

July 8, 2010 July 19, 2010 July 20, 2010 July 23, 2010 July 27, 2010 July 29, 2010 November 22, 2010	Chronic Pain Management – CPT code 97799-CP (5 hours X 7 dates = 35 hours)	$500.00/day	$3500.00
July 26, 2010 December 9, 2010	Chronic Pain Management – CPT code 97799-CP (3 hours x 2 dates = 6 hours)	$300.00/day	$600.00
August 3, 2010 December 21, 2010	CPT Code 99214	$149.57/day	$296.84
August 5, 2010 September 28, 2010 December 21, 2010	CPT Code 99080-73	$15.00/day	$0.00
August 6, 2010 September 28, 2010	CPT Code 99213	$99.68/day	$198.26
TOTAL		$12,643.50	$12,195.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.203 titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
4. 28 Texas Administrative Code §129.5 titled *Work Status Reports*, effective July 16, 2000, 25 TexReg 6520, sets out the requirements for work status reports.
5. Neither party to this dispute submitted any copies of explanation of benefits for the disputed date of service.

Issues

1. Did the respondent support payment was made in accordance with fee guidelines?
2. Is the requestor entitled to reimbursement for the chronic pain management program?
3. Is the requestor entitled to reimbursement for CPT code 99214?
4. Is the requestor entitled to reimbursement for CPT code 99080-73?
5. Is the requestor entitled to reimbursement for CPT code 99213?

Findings

1. The requestor states in the position summary that "No EOB/Pre-authorized - #100623-185885."

   On June 23, 2010, the requestor obtained preauthorization approval for "10 = 80 Hrs. Visits".
   The preauthorization report indicates that "patient had a return to work 6/05 with restrictions and used over the counter medications only…(Note: these will be utilized at 4 hrs per day as claimant continues to work.)."

   On October 12, 2010, the requestor obtained preauthorization approval for five additional visits.

   The Division finds that the requestor has supported the position that the disputed treatment was preauthorized.

2. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs:

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP for 117 hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (5)(A) and (B), the MAR for a non-CARF accredited program is $100.00 per hour ($125.00 X 80%). $100.00 times the 117 hours billed is $11700.00. The respondent paid $0.00. The difference between the MAR and amount paid is $11700.00. This amount is recommended for reimbursement.

3. On the disputed dates of service, the requestor billed for two office visits coded "99214 -Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family".

   Division rule at 28 TAC §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."
   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75050, which is located in Dallas County.

   The MAR for CPT code 99214 in Dallas County is $148.42 (WC Conv 54.32/Medicare Conversion 36.8729 X $100.75 participating amount) X 2 dates = $296.84. The respondent paid $0.00. The difference between the MAR and amount paid is $296.84; this amount is recommended for reimbursement.

4. On the disputed dates of service the requestor billed for three work status reports code 99080-73. Per 28 Texas Administrative Code §129.5(d), "The doctor shall file the Work Status Report: 1) after the initial examination of the employee, regardless of the employee's work status; 2) when the employee experiences a change in work status or a substantial change in activity restrictions; and 3) on the schedule requested by the insurance carrier (carrier) its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee." The requestor did not submit copies of the DWC-73 reports to support billed service was in accordance with 28 Texas Administrative Code §129.5. As a result, reimbursement is not recommended.

5. On the disputed dates of service, the requestor billed for two office visits coded "99213-Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family."

The MAR for CPT code 99213 in Dallas County is $99.13 (WC Conv 54.32/Medicare Conversion 36.8729 X $67.29 participating amount) X 2 dates = $198.26. The respondent paid $0.00. The difference between the MAR and amount paid is $198.26; this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. The Division concludes that the requestor supported its position that reimbursement is due. As a result, the amount ordered is $12,195.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $12,195.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		5/02/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.